

The Merrison and Greenfield reports and the Limited List

Darrin Baines MSc, PhD

In our series on the history of prescribing policy, Dr Darrin Baines traces how successive governments have attempted to curb drug costs. Here, he describes the recommendations made by the Merrison and Greenfield reports and the introduction of the Limited List.

KEY EVENTS

- **1979** Merrison Committee final report – the Royal Commission into the NHS chaired by Alec Merrison produced its findings
- **1979** Prescription charge increase – first increase in eight years, with annual increases then becoming a regular feature of prescribing policy
- **1980** Greenfield Report commissioned – GMSC and RCGP establish a joint working group on effective prescribing in general practice, chaired by Dr Greenfield
- **1984** Limited List introduced – Secretary of State announced his intention to limit the range of drugs that GPs could prescribe, producing estimated savings of £75 million
- **1986** General practice green paper published – *Primary Health Care: An Agenda for Discussion* announced that annual cash limits for prescribing were not practicable

Two months after the Conservative government's victory at the May 1979 general election, the Merrison Committee published its final report.¹ During its investigation, the committee had commissioned a briefing paper on prescribing in general practice, which was written by Mr HSE Gravelle.² In his paper, Mr Gravelle argued that GPs had little incentive to keep drug costs down because any savings that they generated were spread over all taxpayers, so that individual practitioners received insignificant benefits from even very large savings. Moreover, a reduction in the number of scripts issued would probably have required some family doctors to spend more time

with each patient, thus increasing their workloads.

Given the range of policy instruments that could have been introduced, Mr Gravelle asked:

- Should patients pay for the whole or a proportion of their prescriptions or should a limited list be introduced?
- Should GPs or family practitioner committees (FPCs) be given prescribing budgets and how should they be determined?
- Would controls on prescribing represent an unacceptable reduction in GPs' clinical freedom?
- Would controls be preferable to a voluntary system based upon improved information and peer review?
- What forms might control take?

In response to the first of Mr Gravelle's questions, the Merrison Report suggested that the introduction of a limited list 'should lead to improvement in the quality of prescribing by the elimination of ineffective and unnecessarily expensive drugs'. Against the background of the remaining questions, the committee did not suggest any further reductions in prescribing freedoms.

As plans to computerise prescribing data suggested by the Tricker Report were still underway, the recommendations of the Merrison Committee suggest that voluntary peer-review was favoured over limitations of the freedom to prescribe.

Raised prescription charge

In the month that the Merrison Report was published in 1979, the Conservative government raised the prescription charge to 45p per item.

In response, the chairman of the General Medical Services Committee (GMSC), Dr RA Keable-Elliot, argued that the charge and its associated exemptions were 'illogical'. He sug-

gested that there should be unified general practice, hospital and pharmaceutical services budgets. Then, charges should be levied on all drugs prescribed in primary and secondary care, and no patient should be exempt from the fee unless genuine financial hardship was established.³

Despite Dr Keable-Elliot's objections, the prescription charge (with an unaltered structure or exemptions) became the mainstay of Conservative pharmaceutical policy, with 18 increases being introduced between April 1980 and April 1997.

Although initially ignored by the Conservative government, calls for improved budgeting also came from Frank Honigsbaum, a self-employed historian working in London, who wrote to the *BMJ* outlining a 'method by which considerable savings might be realised in prescribing costs'.³

In his letter, Mr Honigsbaum suggested that, annually, GPs could be set a 'target sum' to cover the cost of their patients' drugs. If total expenditure stayed below the amount set, doctors could be allowed to keep one-half of the savings generated. In other words, the historian was suggesting a system similar to the Floating Sixpence run under the National Insurance Scheme.

Given the benefits that a similar scheme had produced in America, Mr Honigsbaum concluded that 'provided suitable safeguards can be established to prevent neglect, the experiment seems worth trying in Britain'. Although not mentioned by Mr Honigsbaum, the Floating Sixpence was abolished in 1920 because its incentives led to the widespread rationing of drugs.

The Greenfield Report

Even though many commentators had views on how their prescribing behaviour could be improved, the Conservative government initially shied away from measures designed to reduce the freedoms that had been granted to GPs. On the contrary, the new government favoured a collaborative and voluntarily approach to improving general practice prescribing, in which representatives of the professions were consulted before any

major pharmaceutical policies were introduced.

For example, in June 1980 the Minister for Health, Dr Gerard Vaughan, asked the GMSC and the Royal College of General Practitioners to establish a joint working group on effective prescribing in general practice.⁴ Following the invitation, the group, chaired by Dr RR Greenfield from the DHSS, first met in December 1980 and presented its final report to Norman Fowler, the Secretary of State for Social Services, in February 1982.⁶ However, due to delays by the Secretary of State, the report was not made available to the public until February 1983.

Once published, the Greenfield Report revealed that the joint committee had made a number of recommendations that it believed to be 'consistent with good medical practice and patient care, which leave the doctor free to make the final clinical decision but which also encourage a more economical approach to prescribing'. In keeping with its emphasis on securing voluntary improvements in prescribing, the committee recommended that:

1. the DHSS should continue to fund the distribution of the *BNF* and other publications designed to promote rational prescribing
2. family doctors should receive frequent, detailed analyses of their own prescribing patterns and costs
3. when visiting high-cost prescribers, regional medical officers should put the emphasis on encouragement, support and advice
4. local drug and therapeutics committees and formularies should be developed
5. the education of GPs and patients should be improved and the purchase of over-the-counter (OTC) drugs encouraged
6. individual drug treatment cards should be used to rationalise therapy and minimise harmful drug interactions
7. generic prescribing should be encouraged by providing a box on prescription pads that GPs could initial if the proprietary version of a medicine is required.

In line with its emphasis on maintaining the freedoms that had been granted to GPs, the Greenfield Report provided

few short-term solutions to the problem of growing public expenditure on drugs. Indeed, among its recommendations, only automatic generic substitution would have produced sizeable and immediate reductions in costs. As the measure would have been unacceptable to the medical profession and damaging to the pharmaceutical industry, automatic substitution was not seen as a feasible policy option at the time.

Binder Hamlyn

During the early 1980s, the Conservative government commissioned the accountants Binder Hamlyn to write a confidential report on the management of general medical services.⁷ Like the Greenfield Committee, Binder Hamlyn recommended against the introduction of cash limits for general practice as the company believed that they would have been inoperable because of the contractual arrangements for GPs.

Therefore, in keeping with the dictum of Say's Law ('supply creates its own demand'), the accountants recommended the restriction of practitioner numbers as a means of controlling costs. Although such restrictions may have produced significant benefits in the longer term, the government decided against this move on the grounds that diminished numbers could have reduced competition, which in turn could have decreased general practice quality and choice.

The Limited List

Given the failure of the Greenfield Committee and Binder Hamlyn to recommend any feasible, short-term policy solutions, the Conservative government had to decide whether to risk alienating the profession by increasing the controls placed on individual GPs or to continue with the voluntary approach favoured by the doctors' representatives and previous administrations.

As Mr Gravelle and others had suggested, if the former approach was adopted the government had two main policy options: a limited list could have been introduced or some form of prescribing budget employed. While the former demanded action at a national

level (for example, in defining and removing restricted products), the latter required a range of local information, infrastructure and support that the NHS did not possess. Indeed, unless better prescribing data became available, new roles and responsibilities were assigned to FPCs and methods for setting prescribing budgets were developed, the second option could not be put into place.

Given the large number of tasks that needed to be completed before prescribing budgets could be introduced, in November 1984 the Secretary of State announced his intention to limit the range of drugs that GPs could prescribe.⁸ Although the idea for a limited list had previously received support from both the Merrison Committee and the Labour Party, the GMSC 'came out strongly against the government's intention', with several of its members predicting that a 'two-tier' NHS would be created.⁹

As a result of the medical profession's opposition and fierce campaigning by the pharmaceutical industry, the Secretary of State was forced to scale down his plans. In consequence, the Limited List that was introduced in April 1985 only restricted the medicines that could be prescribed in seven major therapeutic categories, producing estimated savings of £75 million (rather than the originally planned £100 million) in the first year.¹⁰

According to the Official Historian of the NHS, Charles Webster, the Limited List episode was 'an apparent humiliation for a government increasing renowned for its success in confrontations with corporate interests'.

Nevertheless, Webster argued that the experience also proved to be valuable for the Thatcher administration, as it sug-

gested that radical policy initiatives could be introduced without prior consultation with the medical profession or the establishment of a formal investigation or royal commission.

In consequence, he concluded that the episode 'constituted a firm platform for further and more audacious forays into the primary-care policy arena'.

A green paper

Four months after the introduction of the Limited List, the general practice green paper *Primary Health Care: An Agenda for Discussion* was published.¹¹ Based upon consultations with interested practitioners, providers, professional bodies, policy analysts and patient groups, the document stated that:

'Because the cost of the family practitioner services is to a substantial extent driven by demands placed on the services, particularly for medicines, it is currently difficult to control many of the factors which determine the overall level of expenditure in the short term. The normal discipline of annual cash limits is not therefore practicable either for the family practitioner services alone or jointly with the hospital and community health services.'

Following the introduction of the Limited List, the above quotation suggests that the Conservative government did not want to further alienate GPs by proposing greater constraints upon their prescribing behaviour. On the contrary, the green paper recommended the introduction of a range of minor measures that avoided increased government control of family doctors.

For example, the document suggested extending the range of products available without a prescription, promoting the use of local formularies and encouraging GPs not to prescribe when

unnecessary. Moreover, the paper stated that, once better prescribing data became available, 'the possibility of using this information to increase the incentives for cost-effective prescribing will be explored'.

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Darrin Baines is associate professor, Faculty of Medicine and Health Sciences, University of Nottingham

The next article in the series will look at the introduction of electronic prescribing data and Alan Maynard's suggestions for a budget-holding scheme.



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